PUBLIC HEALTH SERVICE ACT

[As Amended Through P.L. 117–86, Enacted February 18, 2022]

[Currency: This publication is a compilation of the text of title XXVIII of Chapter 373 of the 78th Congress. It was last amended by the public law listed in the As Amended Through note above and below at the bottom of each page of the pdf version and reflects current law through the date of the enactment of the public law listed at https://www.govinfo.gov/app/collection/comps/]

[Note: While this publication does not represent an official version of any Federal statute, substantial efforts have been made to ensure the accuracy of its contents. The official version of Federal law is found in the United States Statutes at Large and in the United States Code. The legal effect to be given to the Statutes at Large and the United States Code is established by statute (1 U.S.C. 112, 204).]

TITLE XXVIII—NATIONAL ALL-HAZARDS PREPAREDNESS FOR PUBLIC HEALTH EMERGENCIES

Subtitle A—National All-Hazards Preparedness and Response Planning, Coordinating, and Reporting

SEC. 2801. [42 U.S.C. 300hh] PUBLIC HEALTH AND MEDICAL PREPAREDNESS AND RESPONSE FUNCTIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall lead all Federal public health and medical response to public health emergencies and incidents covered by the National Response Plan developed pursuant to section 502(6) of the Homeland Security Act of 2002, or any successor plan.

(b) INTERAGENCY AGREEMENT.—The Secretary, in collaboration with the Secretary of Veterans Affairs, the Secretary of Transportation, the Secretary of Defense, the Secretary of Homeland Security, and the head of any other relevant Federal agency, shall establish an interagency agreement, consistent with the National Response Plan or any successor plan, under which agreement the Secretary of Health and Human Services shall assume operational control of emergency public health and medical response assets, as necessary, in the event of a public health emergency, except that members of the armed forces under the authority of the Secretary of Defense shall remain under the command and control of the Secretary of Defense, as shall any associated assets of the Department of Defense.

SEC. 2802. [42 U.S.C. 300hh–1] NATIONAL HEALTH SECURITY STRATEGY.

(a) IN GENERAL.—

(1) PREPAREDNESS AND RESPONSE REGARDING PUBLIC HEALTH EMERGENCIES.—Beginning in 2018 and every four years thereafter, the Secretary shall prepare and submit to the relevant committees of Congress a coordinated strategy (to be known as the National Health Security Strategy) and any revisions thereof, and an accompanying implementation plan for public health emergency preparedness and response. Such National Health Security Strategy shall describe potential emergency health security threats and identify the process for achieving the preparedness goals described in subsection (b) to be prepared to identify and respond to such threats and shall be consistent with the national preparedness goal (as described in section 504(a)(19) of the Homeland Security Act of 2002), the National Incident Management System (as defined in section 501(7) of such Act), and the National Response Plan developed pursuant to section 504 of such Act, or any successor plan.

(2) EVALUATION OF PROGRESS.—The National Health Security Strategy shall include an evaluation of the progress made by Federal, State, local, and tribal entities, based on the evidence-based benchmarks and objective standards that measure levels of preparedness established pursuant to section 319C–1(g). Such evaluation shall include aggregate and State-specific breakdowns of obligated funding spent by major category (as defined by the Secretary) for activities funded through awards pursuant to sections 319C–1 and 319C–2, and an analysis of any changes to the evidence-based benchmarks and objective standards under sections 319C–1 and 319C–2.

(3) PUBLIC HEALTH WORKFORCE.—In 2022, the National Health Security Strategy shall include a national strategy for establishing an effective and prepared public health workforce, including defining the functions, capabilities, and gaps in such workforce (including gaps in the environmental health and animal health workforces, as applicable), describing the status of such workforce, identifying strategies to recruit, retain, and protect such workforce from workplace exposures during public health emergencies, and identifying current capabilities to meet the requirements of section 2803.

(b) PREPAREDNESS GOALS.—The National Health Security Strategy shall include provisions in furtherance of the following:

(1) INTEGRATION.—Integrating public health and public and private medical capabilities with other first responder systems, including through—

(A) the periodic evaluation of Federal, State, local, and tribal preparedness and response capabilities through drills and exercises, including drills and exercises to ensure medical surge capacity for events without notice; and

(B) integrating public and private sector public health and medical donations and volunteers.

(2) PUBLIC HEALTH.—Developing and sustaining Federal, State, local, and tribal essential public health security capabilities, including the following:

(A) Disease situational awareness domestically and abroad, including detection, identification, investigation, and related information technology activities.

(B) Disease containment including capabilities for isolation, quarantine, social distancing, decontamination, relevant health care services and supplies, and transportation and disposal of medical waste.

(C) Risk communication and public preparedness.

(D) Rapid distribution and administration of medical countermeasures.

(E) Response to environmental hazards.

(3) MEDICAL.—Increasing the preparedness, response capabilities, and surge capacity of hospitals, other health care facilities (including pharmacies, mental health facilities, and ambulatory care facilities and which may include dental health facilities), and trauma care, critical care, and emergency medical service systems, with respect to public health emergencies (including related availability, accessibility, and coordination), which shall include developing plans for the following:

(A) Strengthening public health emergency medical and trauma management and treatment capabilities.

(B) Fatality management.

(C) Coordinated medical triage and evacuation to appropriate medical institutions based on patient medical need, taking into account regionalized systems of care.

(D) Rapid distribution and administration of medical countermeasures.

(E) Effective utilization of any available public and private mobile medical assets (which may include such dental health assets) and integration of other Federal assets.

(F) Protecting health care workers and health care first responders from workplace exposures during a public health emergency or exposures to agents that could cause a public health emergency.

(G) Optimizing a coordinated and flexible approach to the emergency response and medical surge capacity of hospitals, other health care facilities, critical care, trauma care (which may include trauma centers), and emergency medical systems.

(4) AT-RISK INDIVIDUALS.—

(A) Taking into account the public health and medical needs of at-risk individuals, including the unique needs and considerations of individuals with disabilities, in the event of a public health emergency.

(B) For the purpose of this Act, the term "at-risk individuals" means children, pregnant women, senior citizens and other individuals who have access or functional needs in the event of a public health emergency, as determined by the Secretary.

(5) COORDINATION.—Minimizing duplication of, and ensuring coordination between, Federal, State, local, and tribal planning, preparedness, and response activities (including the State Emergency Management Assistance Compact and other appli-

cable compacts). Such planning shall be consistent with the National Response Plan, or any successor plan, and National Incident Management System and the National Preparedness Goal.

(6) CONTINUITY OF OPERATIONS.—Maintaining vital public health and medical services to allow for optimal Federal, State, local, and tribal operations in the event of a public health emergency.

(7) COUNTERMEASURES.—

(A) Promoting strategic initiatives to advance countermeasures to diagnose, mitigate, prevent, or treat harm from any biological agent or toxin, chemical, radiological, or nuclear agent or agents, whether naturally occurring, unintentional, or deliberate.

(B) For purposes of this paragraph, the term "countermeasures" has the same meaning as the terms "qualified countermeasures" under section 319F–1, "qualified pandemic and epidemic products" under section 319F–3, and "security countermeasures" under section 319F–2.

(8) MEDICAL AND PUBLIC HEALTH COMMUNITY RESILIENCY.—Strengthening the ability of States, local communities, and tribal communities to prepare for, respond to, and be resilient in the event of public health emergencies, whether naturally occurring, unintentional, or deliberate by—

(A) optimizing alignment and integration of medical and public health preparedness and response planning and capabilities with and into routine daily activities; and

(B) promoting familiarity with local medical and public health systems.

(9) ZOONOTIC DISEASE, FOOD, AND AGRICULTURE.—Improving coordination among Federal, State, local, Tribal, and territorial entities (including through consultation with the Secretary of Agriculture) to prevent, detect, and respond to outbreaks of plant or animal disease (including zoonotic disease) that could compromise national security resulting from a deliberate attack, a naturally occurring threat, the intentional adulteration of food, or other public health threats, taking into account interactions between animal health, human health, and animals' and humans' shared environment as directly related to public health emergency preparedness and response capabilities, as applicable.

(10) GLOBAL HEALTH SECURITY.—Assessing current or potential health security threats from abroad to inform domestic public health preparedness and response capabilities.

SEC. 2803. [42 U.S.C. 300hh–2] ENHANCING MEDICAL SURGE CAPACITY.

(a) STUDY OF ENHANCING MEDICAL SURGE CAPACITY.—As part of the joint review described in section 2812(b), the Secretary shall evaluate the benefits and feasibility of improving the capacity of the Department of Health and Human Services to provide additional medical surge capacity to local communities in the event of a public health emergency. Such study shall include an assessment of the need for and feasibility of improving surge capacity through—

(1) acquisition and operation of mobile medical assets by the Secretary to be deployed, on a contingency basis, to a community in the event of a public health emergency;

(2) integrating the practice of telemedicine within the National Disaster Medical System; and

(3) other strategies to improve such capacity as determined appropriate by the Secretary.

(b) AUTHORITY TO ACQUIRE AND OPERATE MOBILE MEDICAL ASSETS.—In addition to any other authority to acquire, deploy, and operate mobile medical assets, the Secretary may acquire, deploy, and operate mobile medical assets if, taking into consideration the evaluation conducted under subsection (a), such acquisition, deployment, and operation is determined to be beneficial and feasible in improving the capacity of the Department of Health and Human Services to provide additional medical surge capacity to local communities in the event of a public health emergency.

(c) USING FEDERAL FACILITIES TO ENHANCE MEDICAL SURGE CAPACITY.—

(1) ANALYSIS.—The Secretary shall conduct an analysis of whether there are Federal facilities which, in the event of a public health emergency, could practicably be used as facilities in which to provide health care.

(2) MEMORANDA OF UNDERSTANDING.—If, based on the analysis conducted under paragraph (1), the Secretary determines that there are Federal facilities which, in the event of a public health emergency, could be used as facilities in which to provide health care, the Secretary shall, with respect to each such facility, seek to conclude a memorandum of understanding with the head of the Department or agency that operates such facility that permits the use of such facility to provide health care in the event of a public health emergency.

Subtitle B—All-Hazards Emergency Preparedness and Response

SEC. 2811. [42 U.S.C. 300hh–10] COORDINATION OF PREPAREDNESS FOR AND RESPONSE TO ALL-HAZARDS PUBLIC HEALTH EMERGENCIES.

(a) IN GENERAL.—There is established within the Department of Health and Human Services the position of the Assistant Secretary for Preparedness and Response. The President, with the advice and consent of the Senate, shall appoint an individual to serve in such position. Such Assistant Secretary shall report to the Secretary.

(b) DUTIES.—Subject to the authority of the Secretary, the Assistant Secretary for Preparedness and Response shall utilize experience related to public health emergency preparedness and response, biodefense, medical countermeasures, and other relevant topics to carry out the following functions:

(1) LEADERSHIP.—Serve as the principal advisor to the Secretary on all matters related to Federal public health and medical preparedness and response for public health emergencies.

(2) PERSONNEL.—Register, credential, organize, train, equip, and have the authority to deploy Federal public health and medical personnel under the authority of the Secretary, including the National Disaster Medical System, and coordinate such personnel with the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals.

(3) COUNTERMEASURES.—Oversee advanced research, development, and procurement of qualified countermeasures (as defined in section 319F–1), security countermeasures (as defined in section 319F–2), and qualified pandemic or epidemic products (as defined in section 319F–3).

(4) COORDINATION.—

(A) FEDERAL INTEGRATION.—Coordinate with relevant Federal officials to ensure integration of Federal preparedness and response activities for public health emergencies.

(B) STATE, LOCAL, AND TRIBAL INTEGRATION.—Coordinate with State, local, and tribal public health officials, the Emergency Management Assistance Compact, health care systems, and emergency medical service systems to ensure effective integration of Federal public health and medical assets during a public health emergency.

(C) EMERGENCY MEDICAL SERVICES.—Promote improved emergency medical services medical direction, system integration, research, and uniformity of data collection, treatment protocols, and policies with regard to public health emergencies.

(D) POLICY COORDINATION AND STRATEGIC DIRECTION.—Provide integrated policy coordination and strategic direction, before, during, and following public health emergencies, with respect to all matters related to Federal public health and medical preparedness and execution and deployment of the Federal response for public health emergencies and incidents covered by the National Response Plan described in section 504(a)(6) of the Homeland Security Act of 2002 (6 U.S.C. 314(a)(6)), or any successor plan; and such Federal responses covered by the National Cybersecurity Incident Response Plan developed under section 228(c) of the Homeland Security Act of 2002 (6 U.S.C. 149(c)), including public health emergencies or incidents related to cybersecurity threats that present a threat to national health security.

(E) IDENTIFICATION OF INEFFICIENCIES.—Identify and minimize gaps, duplication, and other inefficiencies in medical and public health preparedness and response activities and the actions necessary to overcome these obstacles.

(F) COORDINATION OF GRANTS AND AGREEMENTS.—Align and coordinate medical and public health grants and cooperative agreements as applicable to preparedness and response activities authorized under this Act, to the extent possible, including program requirements, timelines, and measurable goals, and in consultation with the Secretary of Homeland Security, to—

(i) optimize and streamline medical and public health preparedness and response capabilities and the ability of local communities to respond to public health emergencies; and

(ii) gather and disseminate best practices among grant and cooperative agreement recipients, as appropriate.

(G) DRILL AND OPERATIONAL EXERCISES.—Carry out drills and operational exercises, in consultation with the Department of Homeland Security, the Department of Defense, the Department of Veterans Affairs, and other applicable Federal departments and agencies, as necessary and appropriate, to identify, inform, and address gaps in and policies related to all-hazards medical and public health preparedness and response, including exercises based on—

(i) identified threats for which countermeasures are available and for which no countermeasures are available; and

(ii) unknown threats for which no countermeasures are available.

(H) NATIONAL SECURITY PRIORITY.—On a periodic basis consult with, as applicable and appropriate, the Assistant to the President for National Security Affairs, to provide an update on, and discuss, medical and public health preparedness and response activities pursuant to this Act and the Federal Food, Drug, and Cosmetic Act, including progress on the development, approval, clearance, and licensure of medical countermeasures.

(I) THREAT AWARENESS.—Coordinate with the Director of the Centers for Disease Control and Prevention, the Director of National Intelligence, the Secretary of Homeland Security, the Assistant to the President for National Security Affairs, the Secretary of Defense, and other relevant Federal officials, such as the Secretary of Agriculture, to maintain a current assessment of national security threats and inform preparedness and response capabilities based on the range of the threats that have the potential to result in a public health emergency.

(5) LOGISTICS.—In coordination with the Secretary of Veterans Affairs, the Secretary of Homeland Security, the General Services Administration, and other public and private entities, provide logistical support for medical and public health aspects of Federal responses to public health emergencies. Such logistical support shall include working with other relevant Federal, State, local, Tribal, and territorial public health officials and private sector entities to identify the critical infrastructure assets, systems, and networks needed for the proper functioning of the health care and public health sectors that need to be maintained through any emergency or disaster, including entities capable of assisting with, responding to, and mitigating the effect of a public health emergency, including a public health emergency determined by the Secretary pursuant to section 319(a) or an emergency or major disaster declared by the President under the Robert T. Stafford Disaster Relief and

Emergency Assistance Act or the National Emergencies Act, including by establishing methods to exchange critical information and deliver products consumed or used to preserve, protect, or sustain life, health, or safety, and sharing of specialized expertise.

(6) LEADERSHIP.—Provide leadership in international programs, initiatives, and policies that deal with public health and medical emergency preparedness and response.

(7) COUNTERMEASURES BUDGET PLAN.—Develop, and update not later than March 15 of each year, a coordinated 5-year budget plan based on the medical countermeasure priorities described in subsection (d), including with respect to chemical, biological, radiological, and nuclear agent or agents that may present a threat to the Nation, including such agents that are novel or emerging infectious diseases, and the corresponding efforts to develop qualified countermeasures (as defined in section 319F–1), security countermeasures (as defined in section 319F–2), and qualified pandemic or epidemic products (as defined in section 319F–3) for each such threat. Each such plan shall—

(A) include consideration of the entire medical countermeasures enterprise, including—

(i) basic research and advanced research and development;

(ii) approval, clearance, licensure, and authorized uses of products;

(iii) procurement, stockpiling, maintenance, and potential replenishment (including manufacturing capabilities) of all products in the Strategic National Stockpile;

(iv) the availability of technologies that may assist in the advanced research and development of countermeasures and opportunities to use such technologies to accelerate and navigate challenges unique to countermeasure research and development; and

(v) potential deployment, distribution, and utilization of medical countermeasures; development of clinical guidance and emergency use instructions for the use of medical countermeasures; and, as applicable, potential postdeployment activities related to medical countermeasures;

(B) inform prioritization of resources and include measurable outputs and outcomes to allow for the tracking of the progress made toward identified priorities;

(C) identify medical countermeasure life-cycle costs to inform planning, budgeting, and anticipated needs within the continuum of the medical countermeasure enterprise consistent with section 319F–2;

(D) identify the full range of anticipated medical countermeasure needs related to research and development, procurement, and stockpiling, including the potential need for indications, dosing, and administration technologies, and other countermeasure needs as applicable and appropriate;

(E) be made available, not later than March 15 of each year, to the Committee on Appropriations and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Appropriations and the Committee on Energy and Commerce of the House of Representatives; and

(F) not later than March 15 of each year, be made publicly available in a manner that does not compromise national security.

(c) FUNCTIONS.—The Assistant Secretary for Preparedness and Response shall—

(1) have lead responsibility within the Department of Health and Human Services for emergency preparedness and response policy coordination and strategic direction;

(2) have authority over and responsibility for—

(A) the National Disaster Medical System pursuant to section 2812;

(B) the Hospital Preparedness Cooperative Agreement Program pursuant to section 319C–2;

(C) the Biomedical Advanced Research and Development Authority pursuant to section 319L;

(D) the Medical Reserve Corps pursuant to section 2813;

(E) the Emergency System for Advance Registration of Volunteer Health Professionals pursuant to section 319I; and

(F) administering grants and related authorities related to trauma care under parts A through C of title XII, such authority to be transferred by the Secretary from the Administrator of the Health Resources and Services Administration to such Assistant Secretary;

(3) exercise the responsibilities and authorities of the Secretary with respect to the coordination of—

(A) the Public Health Emergency Preparedness Cooperative Agreement Program pursuant to section 319C–1;

(B) the Strategic National Stockpile pursuant to section 319F–2; and

(C) the Cities Readiness Initiative; and

(4) assume other duties as determined appropriate by the Secretary.

(d) PUBLIC HEALTH EMERGENCY MEDICAL COUNTERMEASURES ENTERPRISE STRATEGY AND IMPLEMENTATION PLAN.—

(1) IN GENERAL.—Not later than March 15, 2020, and biennially thereafter, the Assistant Secretary for Preparedness and Response shall develop and submit to the appropriate committees of Congress a coordinated strategy and accompanying implementation plan for medical countermeasures to address chemical, biological, radiological, and nuclear threats. In developing such a plan, the Assistant Secretary for Preparedness and Response shall consult with the Public Health Emergency Medical Countermeasures Enterprise established under section 2811–1. Such strategy and plan shall be known as the "Public Health Emergency Medical Countermeasures Enterprise Strategy and Implementation Plan".

(2) REQUIREMENTS.—The plan under paragraph (1) shall—

(A) describe the chemical, biological, radiological, and nuclear agent or agents that may present a threat to the Nation and the corresponding efforts to develop qualified countermeasures (as defined in section 319F–1), security countermeasures (as defined in section 319F–2), or qualified pandemic or epidemic products (as defined in section 319F–3) for each threat;

(B) evaluate the progress of all activities with respect to such countermeasures or products, including research, advanced research, development, procurement, stockpiling, deployment, distribution, and utilization;

(C) identify and prioritize near-, mid-, and long-term needs with respect to such countermeasures or products, and ancillary medical supplies to assist with the utilization of such countermeasures or products, to address a chemical, biological, radiological, and nuclear threat or threats;

(D) identify, with respect to each category of threat, a summary of all awards and contracts, including advanced research and development and procurement, that includes—

(i) the time elapsed from the issuance of the initial solicitation or request for a proposal to the adjudication (such as the award, denial of award, or solicitation termination); and

(ii) an identification of projected timelines, anticipated funding allocations, benchmarks, and milestones for each medical countermeasure priority under subparagraph (C), including projected needs with regard to replenishment of the Strategic National Stockpile;

(E) be informed by the recommendations of the National Biodefense Science Board pursuant to section 319M;

(F) evaluate progress made in meeting timelines, allocations, benchmarks, and milestones identified under subparagraph (D)(ii);

(G) report on the amount of funds available for procurement in the special reserve fund as defined in section 319F–2(h) and the impact this funding will have on meeting the requirements under section 319F–2;

(H) incorporate input from Federal, State, local, and tribal stakeholders;

(I) identify the progress made in meeting the medical countermeasure priorities for at-risk individuals (as defined in 2802(b)(4)(B)), as applicable under subparagraph (C), including with regard to the projected needs for related stockpiling and replenishment of the Strategic National Stockpile, including by addressing the needs of pediatric populations with respect to such countermeasures and products in the Strategic National Stockpile, including—

(i) a list of such countermeasures and products necessary to address the needs of pediatric populations;

(ii) a description of measures taken to coordinate with the Office of Pediatric Therapeutics of the Food and Drug Administration to maximize the labeling, dosages, and formulations of such countermeasures and products for pediatric populations;

(iii) a description of existing gaps in the Strategic National Stockpile and the development of such countermeasures and products to address the needs of pediatric populations; and

(iv) an evaluation of the progress made in addressing priorities identified pursuant to subparagraph (C);

(J) identify the use of authority and activities undertaken pursuant to sections 319F–1(b)(1), 319F–1(b)(2), 319F–1(b)(3), 319F–1(c), 319F–1(d), 319F–1(e), 319F–2(c)(7)(C)(iii), 319F–2(c)(7)(C)(iv), and 319F–2(c)(7)(C)(v) of this Act, and subsections (a)(1), (b)(1), and (e) of section 564 of the Federal Food, Drug, and Cosmetic Act, by summarizing—

(i) the particular actions that were taken under the authorities specified, including, as applicable, the identification of the threat agent, emergency, or the biomedical countermeasure with respect to which the authority was used;

(ii) the reasons underlying the decision to use such authorities, including, as applicable, the options that were considered and rejected with respect to the use of such authorities;

(iii) the number of, nature of, and other information concerning the persons and entities that received a grant, cooperative agreement, or contract pursuant to the use of such authorities, and the persons and entities that were considered and rejected for such a grant, cooperative agreement, or contract, except that the report need not disclose the identity of any such person or entity;

(iv) whether, with respect to each procurement that is approved by the President under section 319F–2(c)(6), a contract was entered into within one year after such approval by the President; and

(v) with respect to section 319F–1(d), for the 2-year period for which the report is submitted, the number of persons who were paid amounts totaling $100,000 or greater and the number of persons who were paid amounts totaling at least $50,000 but less than $100,000; and

(K) be made publicly available.

(3) GAO REPORT.—

(A) IN GENERAL.—Not later than 1 year after the date of the submission to the Congress of the first Public Health Emergency Medical Countermeasures Enterprise Strategy and Implementation Plan, the Comptroller General of the United States shall conduct an independent evaluation, and submit to the appropriate committees of

Congress a report, concerning such Strategy and Implementation Plan.

(B) CONTENT.—The report described in subparagraph (A) shall review and assess—

(i) the near-term, mid-term, and long-term medical countermeasure needs and identified priorities of the Federal Government pursuant to paragraph (2)(C);

(ii) the activities of the Department of Health and Human Services with respect to advanced research and development pursuant to section 319L; and

(iii) the progress made toward meeting the timelines, allocations, benchmarks, and milestones identified in the Public Health Emergency Medical Countermeasures Enterprise Strategy and Implementation Plan under this subsection.

(e) PROTECTION OF NATIONAL SECURITY.—In carrying out subsections (b)(7) and (d), the Secretary shall ensure that information and items that could compromise national security, contain confidential commercial information, or contain proprietary information are not disclosed.

(f) PROTECTION OF NATIONAL SECURITY FROM THREATS.—

(1) IN GENERAL.—In carrying out subsection (b)(3), the Assistant Secretary for Preparedness and Response shall implement strategic initiatives or activities to address threats, including pandemic influenza and which may include a chemical, biological, radiological, or nuclear agent (including any such agent with a significant potential to become a pandemic), that pose a significant level of risk to public health and national security based on the characteristics of such threat. Such initiatives shall include activities to—

(A) accelerate and support the advanced research, development, manufacturing capacity, procurement, and stockpiling of countermeasures, including initiatives under section 319L(c)(4)(F);

(B) support the development and manufacturing of virus seeds, clinical trial lots, and stockpiles of novel virus strains; and

(C) maintain or improve preparedness activities, including for pandemic influenza.

(2) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—To carry out this subsection, there is authorized to be appropriated $250,000,000 for each of fiscal years 2019 through 2023.

(B) SUPPLEMENT, NOT SUPPLANT.—Amounts appropriated under this paragraph shall be used to supplement and not supplant funds provided under sections 319L(d) and 319F–2(g).

(C) DOCUMENTATION REQUIRED.—The Assistant Secretary for Preparedness and Response, in accordance with subsection (b)(7), shall document amounts expended for purposes of carrying out this subsection, including amounts appropriated under the heading "Public Health and Social Services Emergency Fund" under the heading "Office of the Secretary" under title II of division H of the

Consolidated Appropriations Act, 2018 (Public Law 115–141) and allocated to carrying out section 319L(c)(4)(F).

SEC. 2811–1. [42 U.S.C. 300hh–10a] PUBLIC HEALTH EMERGENCY MEDICAL COUNTERMEASURES ENTERPRISE.

(a) IN GENERAL.—The Secretary shall establish the Public Health Emergency Medical Countermeasures Enterprise (referred to in this section as the "PHEMCE"). The Assistant Secretary for Preparedness and Response shall serve as chair of the PHEMCE.

(b) MEMBERS.—The PHEMCE shall include each of the following members, or the designee of such members:

(1) The Assistant Secretary for Preparedness and Response.

(2) The Director of the Centers for Disease Control and Prevention.

(3) The Director of the National Institutes of Health.

(4) The Commissioner of Food and Drugs.

(5) The Secretary of Defense.

(6) The Secretary of Homeland Security.

(7) The Secretary of Agriculture.

(8) The Secretary of Veterans Affairs.

(9) The Director of National Intelligence.

(10) Representatives of any other Federal agency, which may include the Director of the Biomedical Advanced Research and Development Authority, the Director of the Strategic National Stockpile, the Director of the National Institute of Allergy and Infectious Diseases, and the Director of the Office of Public Health Preparedness and Response, as the Secretary determines appropriate.

(c) FUNCTIONS.—

(1) IN GENERAL.—The functions of the PHEMCE shall include the following:

(A) Utilize a process to make recommendations to the Secretary regarding research, advanced research, development, procurement, stockpiling, deployment, distribution, and utilization with respect to countermeasures, as defined in section 319F–2(c), including prioritization based on the health security needs of the United States. Such recommendations shall be informed by, when available and practicable, the National Health Security Strategy pursuant to section 2802, the Strategic National Stockpile needs pursuant to section 319F–2, and assessments of current national security threats, including chemical, biological, radiological, and nuclear threats, including emerging infectious diseases. In the event that members of the PHEMCE do not agree upon a recommendation, the Secretary shall provide a determination regarding such recommendation.

(B) Identify national health security needs, including gaps in public health preparedness and response related to countermeasures and challenges to addressing such needs (including any regulatory challenges), and support alignment of countermeasure procurement with recommendations to address such needs under subparagraph (A).

(C) Assist the Secretary in developing strategies related to logistics, deployment, distribution, dispensing, and

use of countermeasures that may be applicable to the activities of the strategic national stockpile under section 319F–2(a).

(D) Provide consultation for the development of the strategy and implementation plan under section 2811(d).

(2) INPUT.—In carrying out subparagraphs (B) and (C) of paragraph (1), the PHEMCE shall solicit and consider input from State, local, Tribal, and territorial public health departments or officials, as appropriate.

SEC. 2811A. [42 U.S.C. 300hh–10b] NATIONAL ADVISORY COMMITTEE ON CHILDREN AND DISASTERS.

(a) ESTABLISHMENT.—The Secretary, in consultation with the Secretary of Homeland Security, shall establish an advisory committee to be known as the "National Advisory Committee on Children and Disasters" (referred to in this section as the "Advisory Committee").

(b) DUTIES.—The Advisory Committee shall—

(1) provide advice and consultation with respect to the activities carried out pursuant to section 2814, as applicable and appropriate;

(2) evaluate and provide input with respect to the medical, mental and behavioral, and public health needs of children as they relate to preparation for, response to, and recovery from all-hazards emergencies; and

(3) provide advice and consultation with respect to State emergency preparedness and response activities and children, including related drills and exercises pursuant to the preparedness goals under section 2802(b).

(c) ADDITIONAL DUTIES.—The Advisory Committee may provide advice and recommendations to the Secretary with respect to children and the medical and public health grants and cooperative agreements as applicable to preparedness and response activities authorized under this title and title III.

(d) MEMBERSHIP.—

(1) IN GENERAL.—The Secretary, in consultation with such other Secretaries as may be appropriate, shall appoint not to exceed 25 members to the Advisory Committee. In appointing such members, the Secretary shall ensure that the total membership of the Advisory Committee is an odd number.

(2) REQUIRED NON-FEDERAL MEMBERS.—The Secretary, in consultation with such other heads of Federal agencies as may be appropriate, shall appoint to the Advisory Committee under paragraph (1) at least 13 individuals, including—

(A) at least 2 non-Federal professionals with expertise in pediatric medical disaster planning, preparedness, response, or recovery;

(B) at least 2 representatives from State, local, Tribal, or territorial agencies with expertise in pediatric disaster planning, preparedness, response, or recovery;

(C) at least 4 members representing health care professionals, which may include members with expertise in pediatric emergency medicine; pediatric trauma, critical care, or surgery; the treatment of pediatric patients affected by chemical, biological, radiological, or nuclear

agents, including emerging infectious diseases; pediatric mental or behavioral health related to children affected by a public health emergency; or pediatric primary care; and

(D) other members as the Secretary determines appropriate, of whom—

(i) at least one such member shall represent a children's hospital;

(ii) at least one such member shall be an individual with expertise in schools or child care settings;

(iii) at least one such member shall be an individual with expertise in children and youth with special health care needs; and

(iv) at least one such member shall be an individual with expertise in the needs of parents or family caregivers, including the parents or caregivers of children with disabilities.

(3) FEDERAL MEMBERS.—The Advisory Committee under paragraph (1) shall include the following Federal members or their designees (who may be nonvoting members, as determined by the Secretary):

(A) The Assistant Secretary for Preparedness and Response.

(B) The Director of the Biomedical Advanced Research and Development Authority.

(C) The Director of the Centers for Disease Control and Prevention.

(D) The Commissioner of Food and Drugs.

(E) The Director of the National Institutes of Health.

(F) The Assistant Secretary of the Administration for Children and Families.

(G) The Administrator of the Health Resources and Services Administration.

(H) The Administrator of the Federal Emergency Management Agency.

(I) The Administrator of the Administration for Community Living.

(J) The Secretary of Education.

(K) Representatives from such Federal agencies (such as the Substance Abuse and Mental Health Services Administration and the Department of Homeland Security) as the Secretary determines appropriate to fulfill the duties of the Advisory Committee under subsections (b) and (c).

(4) TERM OF APPOINTMENT.—Each member of the Advisory Committee appointed under paragraph (2) shall serve for a term of 3 years, except that the Secretary may adjust the terms of the Advisory Committee appointees serving on the date of enactment of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019, or appointees who are initially appointed after such date of enactment, in order to provide for a staggered term of appointment for all members.

(5) CONSECUTIVE APPOINTMENTS; MAXIMUM TERMS.—A member appointed under paragraph (2) may serve not more

than 3 terms on the Advisory Committee, and not more than two of such terms may be served consecutively.

(e) MEETINGS.—The Advisory Committee shall meet not less than biannually. At least one meeting per year shall be an in-person meeting.

(f) COORDINATION.—The Secretary shall coordinate duties and activities authorized under this section in accordance with section 2811D.

(g) SUNSET.—The Advisory Committee shall terminate on September 30, 2023.

SEC. 2811B. [42 U.S.C. 300hh-10c] NATIONAL ADVISORY COMMITTEE ON SENIORS AND DISASTERS.

(a) ESTABLISHMENT.—The Secretary, in consultation with the Secretary of Homeland Security and the Secretary of Veterans Affairs, shall establish an advisory committee to be known as the National Advisory Committee on Seniors and Disasters (referred to in this section as the "Advisory Committee").

(b) DUTIES.—The Advisory Committee shall—

(1) provide advice and consultation with respect to the activities carried out pursuant to section 2814, as applicable and appropriate;

(2) evaluate and provide input with respect to the medical and public health needs of seniors related to preparation for, response to, and recovery from all-hazards emergencies; and

(3) provide advice and consultation with respect to State emergency preparedness and response activities relating to seniors, including related drills and exercises pursuant to the preparedness goals under section 2802(b).

(c) ADDITIONAL DUTIES.—The Advisory Committee may provide advice and recommendations to the Secretary with respect to seniors and the medical and public health grants and cooperative agreements as applicable to preparedness and response activities under this title and title III.

(d) MEMBERSHIP.—

(1) IN GENERAL.—The Secretary, in consultation with such other heads of agencies as appropriate, shall appoint not more than 17 members to the Advisory Committee. In appointing such members, the Secretary shall ensure that the total membership of the Advisory Committee is an odd number.

(2) REQUIRED MEMBERS.—The Advisory Committee shall include Federal members or their designees (who may be nonvoting members, as determined by the Secretary) and non-Federal members, as follows:

(A) The Assistant Secretary for Preparedness and Response.

(B) The Director of the Biomedical Advanced Research and Development Authority.

(C) The Director of the Centers for Disease Control and Prevention.

(D) The Commissioner of Food and Drugs.

(E) The Director of the National Institutes of Health.

(F) The Administrator of the Centers for Medicare & Medicaid Services.

(G) The Administrator of the Administration for Community Living.

(H) The Administrator of the Federal Emergency Management Agency.

(I) The Under Secretary for Health of the Department of Veterans Affairs.

(J) At least 2 non-Federal health care professionals with expertise in geriatric medical disaster planning, preparedness, response, or recovery.

(K) At least 2 representatives of State, local, Tribal, or territorial agencies with expertise in geriatric disaster planning, preparedness, response, or recovery.

(L) Representatives of such other Federal agencies (such as the Department of Energy and the Department of Homeland Security) as the Secretary determines necessary to fulfill the duties of the Advisory Committee.

(e) MEETINGS.—The Advisory Committee shall meet not less frequently than biannually. At least one meeting per year shall be an in-person meeting.

(f) COORDINATION.—The Secretary shall coordinate duties and activities authorized under this section in accordance with section 2811D.

(g) SUNSET.—

(1) IN GENERAL.—The Advisory Committee shall terminate on September 30, 2023.

(2) EXTENSION OF COMMITTEE.—Not later than October 1, 2022, the Secretary shall submit to Congress a recommendation on whether the Advisory Committee should be extended.

SEC. 2811C. [42 U.S.C. 300hh-10d] NATIONAL ADVISORY COMMITTEE ON INDIVIDUALS WITH DISABILITIES AND DISASTERS.

(a) ESTABLISHMENT.—The Secretary, in consultation with the Secretary of Homeland Security, shall establish a national advisory committee to be known as the National Advisory Committee on Individuals with Disabilities and Disasters (referred to in this section as the "Advisory Committee").

(b) DUTIES.—The Advisory Committee shall—

(1) provide advice and consultation with respect to activities carried out pursuant to section 2814, as applicable and appropriate;

(2) evaluate and provide input with respect to the medical, public health, and accessibility needs of individuals with disabilities related to preparation for, response to, and recovery from all-hazards emergencies; and

(3) provide advice and consultation with respect to State emergency preparedness and response activities, including related drills and exercises pursuant to the preparedness goals under section 2802(b).

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Secretary, in consultation with such other heads of agencies and departments as appropriate, shall appoint not more than 17 members to the Advisory Committee. In appointing such members, the Secretary shall ensure that the total membership of the Advisory Committee is an odd number.

(2) REQUIRED MEMBERS.—The Advisory Committee shall include Federal members or their designees (who may be non-voting members, as determined by the Secretary) and non-Federal members, as follows:

(A) The Assistant Secretary for Preparedness and Response.

(B) The Administrator of the Administration for Community Living.

(C) The Director of the Biomedical Advanced Research and Development Authority.

(D) The Director of the Centers for Disease Control and Prevention.

(E) The Commissioner of Food and Drugs.

(F) The Director of the National Institutes of Health.

(G) The Administrator of the Federal Emergency Management Agency.

(H) The Chair of the National Council on Disability.

(I) The Chair of the United States Access Board.

(J) The Under Secretary for Health of the Department of Veterans Affairs.

(K) At least 2 non-Federal health care professionals with expertise in disability accessibility before, during, and after disasters, medical and mass care disaster planning, preparedness, response, or recovery.

(L) At least 2 representatives from State, local, Tribal, or territorial agencies with expertise in disaster planning, preparedness, response, or recovery for individuals with disabilities.

(M) At least 2 individuals with a disability with expertise in disaster planning, preparedness, response, or recovery for individuals with disabilities.

(d) MEETINGS.—The Advisory Committee shall meet not less frequently than biannually. At least one meeting per year shall be an in-person meeting.

(e) DISABILITY DEFINED.—For purposes of this section, the term "disability" has the meaning given such term in section 3 of the Americans with Disabilities Act of 1990.

(f) COORDINATION.—The Secretary shall coordinate duties and activities authorized under this section in accordance with section 2811D.

(g) SUNSET.—

(1) IN GENERAL.—The Advisory Committee shall terminate on September 30, 2023.

(2) RECOMMENDATION.—Not later than October 1, 2022, the Secretary shall submit to Congress a recommendation on whether the Advisory Committee should be extended.

SEC. 2811D. [42 U.S.C. 300hh-10e] ADVISORY COMMITTEE COORDINATION.

(a) IN GENERAL.—The Secretary shall coordinate duties and activities authorized under sections 2811A, 2811B, and 2811C, and make efforts to reduce unnecessary or duplicative reporting, or unnecessary duplicative meetings and recommendations under such sections, as practicable. Members of the advisory committees authorized under such sections, or their designees, shall annually

meet to coordinate any recommendations, as appropriate, that may be similar, duplicative, or overlapping with respect to addressing the needs of children, seniors, and individuals with disabilities during public health emergencies. If such coordination occurs through an in-person meeting, it shall not be considered the required in-person meetings under any of sections 2811A(e), 2811B(e), or 2811C(d).

(b) COORDINATION AND ALIGNMENT.—The Secretary, acting through the employee designated pursuant to section 2814, shall align preparedness and response programs or activities to address similar, dual, or overlapping needs of children, seniors, and individuals with disabilities, and any challenges in preparing for and responding to such needs.

(c) NOTIFICATION.—The Secretary shall annually notify the congressional committees of jurisdiction regarding the steps taken to coordinate, as appropriate, the recommendations under this section, and provide a summary description of such coordination.

SEC. 2812. [42 U.S.C. 300hh–11] NATIONAL DISASTER MEDICAL SYSTEM.

(a) NATIONAL DISASTER MEDICAL SYSTEM.—

(1) IN GENERAL.—The Secretary shall provide for the operation in accordance with this section of a system to be known as the National Disaster Medical System. The Secretary shall designate the Assistant Secretary for Preparedness and Response as the head of the National Disaster Medical System, subject to the authority of the Secretary.

(2) FEDERAL AND STATE COLLABORATIVE SYSTEM.—

(A) IN GENERAL.—The National Disaster Medical System shall be a coordinated effort by the Federal agencies specified in subparagraph (B), working in collaboration with the States and other appropriate public or private entities, to carry out the purposes described in paragraph (3).

(B) PARTICIPATING FEDERAL AGENCIES.—The Federal agencies referred to in subparagraph (A) are the Department of Health and Human Services, the Department of Homeland Security, the Department of Defense, and the Department of Veterans Affairs.

(3) PURPOSE OF SYSTEM.—

(A) IN GENERAL.—The Secretary may activate the National Disaster Medical System to—

(i) provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency, including at-risk individuals as applicable (whether or not determined to be a public health emergency under section 319); or

(ii) be present at locations, and for limited periods of time, specified by the Secretary on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified, or there is a significant potential for a public health emergency.

(B) ONGOING ACTIVITIES.—The National Disaster Medical System shall carry out such ongoing activities as may

be necessary to prepare for the provision of services described in subparagraph (A) in the event that the Secretary activates the National Disaster Medical System for such purposes.

(C) CONSIDERATIONS FOR AT-RISK POPULATIONS.—The Secretary shall take steps to ensure that an appropriate specialized and focused range of public health and medical capabilities are represented in the National Disaster Medical System, which take into account the needs of at-risk individuals, in the event of a public health emergency.

(D) ADMINISTRATION.—The Secretary may determine and pay claims for reimbursement for services under subparagraph (A) directly or through contracts that provide for payment in advance or by way of reimbursement.

(E) TEST FOR MOBILIZATION OF SYSTEM.—During the one-year period beginning on the date of the enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall conduct an exercise to test the capability and timeliness of the National Disaster Medical System to mobilize and otherwise respond effectively to a bioterrorist attack or other public health emergency that affects two or more geographic locations concurrently. Thereafter, the Secretary may periodically conduct such exercises regarding the National Disaster Medical System as the Secretary determines to be appropriate.

(b) MODIFICATIONS.—

(1) IN GENERAL.—Taking into account the findings from the joint review described under paragraph (2), the Secretary shall modify the policies of the National Disaster Medical System as necessary.

(2) JOINT REVIEW AND MEDICAL SURGE CAPACITY STRATEGIC PLAN.—

(A) REVIEW.—Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019, the Secretary, in coordination with the Secretary of Homeland Security, the Secretary of Defense, and the Secretary of Veterans Affairs, shall conduct a joint review of the National Disaster Medical System. Such review shall include—

(i) an evaluation of medical surge capacity, as described in section 2803(a);

(ii) an assessment of the available workforce of the intermittent disaster response personnel described in subsection (c);

(iii) the capacity of the workforce described in clause (ii) to respond to all hazards, including capacity to simultaneously respond to multiple public health emergencies and the capacity to respond to a nationwide public health emergency;

(iv) the effectiveness of efforts to recruit, retain, and train such workforce; and

(v) gaps that may exist in such workforce and recommendations for addressing such gaps.

(B) UPDATES.—As part of the National Health Security Strategy under section 2802, the Secretary shall update the findings from the review under subparagraph (A) and provide recommendations to modify the policies of the National Disaster Medical System as necessary.

(3) PARTICIPATION AGREEMENTS FOR NON-FEDERAL ENTITIES.—In carrying out paragraph (1), the Secretary shall establish criteria regarding the participation of States and private entities in the National Disaster Medical System, including criteria regarding agreements for such participation. The criteria shall include the following:

(A) Provisions relating to the custody and use of Federal personal property by such entities, which may in the discretion of the Secretary include authorizing the custody and use of such property to respond to emergency situations for which the National Disaster Medical System has not been activated by the Secretary pursuant to subsection (a)(3)(A). Any such custody and use of Federal personal property shall be on a reimbursable basis.

(B) Provisions relating to circumstances in which an individual or entity has agreements with both the National Disaster Medical System and another entity regarding the provision of emergency services by the individual. Such provisions shall address the issue of priorities among the agreements involved.

(c) INTERMITTENT DISASTER-RESPONSE PERSONNEL.—

(1) IN GENERAL.—For the purpose of assisting the National Disaster Medical System in carrying out duties under this section, the Secretary may appoint individuals to serve as intermittent personnel of such System in accordance with applicable civil service laws and regulations.

(2) LIABILITY.—For purposes of section 224(a) and the remedies described in such section, an individual appointed under paragraph (1) shall, while acting within the scope of such appointment, be considered to be an employee of the Public Health Service performing medical, surgical, dental, or related functions. With respect to the participation of individuals appointed under paragraph (1) in training programs authorized by the Assistant Secretary for Preparedness and Response or a comparable official of any Federal agency specified in subsection (a)(2)(B), acts of individuals so appointed that are within the scope of such participation shall be considered within the scope of the appointment under paragraph (1) (regardless of whether the individuals receive compensation for such participation).

(3) NOTIFICATION.—Not later than 30 days after the date on which the Secretary determines the number of intermittent disaster-response personnel of the National Disaster Medical System is insufficient to address a public health emergency or potential public health emergency, the Secretary shall submit to the congressional committees of jurisdiction a notification detailing—

(A) the impact such shortage could have on meeting public health needs and emergency medical personnel needs during a public health emergency; and

(B) any identified measures to address such shortage.

(4) CERTAIN APPOINTMENTS.—

(A) IN GENERAL.—If the Secretary determines that the number of intermittent disaster response personnel within the National Disaster Medical System under this section is insufficient to address a public health emergency or potential public health emergency, the Secretary may appoint candidates directly to personnel positions for intermittent disaster response within such system. The Secretary shall provide updates on the number of vacant or unfilled positions within such system to the congressional committees of jurisdiction each quarter for which this authority is in effect.

(B) SUNSET.—The authority under this paragraph shall expire on March 11, 2022.

(5)[1] SERVICE BENEFIT.—Individuals appointed to serve under this subsection shall be considered eligible for benefits under part L of title I of the Omnibus Crime Control and Safe Streets Act of 1968. The Secretary shall provide notification to any eligible individual of any effect such designation may have on other benefits for which such individual is eligible, including benefits from private entities.

(d) CERTAIN EMPLOYMENT ISSUES REGARDING INTERMITTENT APPOINTMENTS.—

(1) INTERMITTENT DISASTER-RESPONSE APPOINTEE.—For purposes of this subsection, the term "intermittent disaster-response appointee" means an individual appointed by the Secretary under subsection (c).

(2) COMPENSATION FOR WORK INJURIES.—

(A) IN GENERAL.—An intermittent disaster-response appointee shall, while acting in the scope of such appointment, be considered to be an employee of the Public Health Service performing medical, surgical, dental, or related functions, and an injury sustained by such an individual shall be deemed "in the performance of duty", for purposes of chapter 81 of title 5, United States Code, pertaining to compensation for work injuries.

(B) APPLICATION TO TRAINING PROGRAMS.—With respect to the participation of individuals appointed under subsection (c) in training programs authorized by the Assistant Secretary for Preparedness and Response or a comparable official of any Federal agency specified in subsection (a)(2)(B), injuries sustained by such an individual, while acting within the scope of such participation, also shall be deemed "in the performance of duty" for purposes of chapter 81 of title 5, United States Code (regardless of whether the individuals receive compensation for such participation).

[1] Paragraph (5) was added by section 301(d)(1) of Public Law 116–22 (enacted June 24, 2019). Paragraph (3) of section 301(d) of such Public Law provides "[t]he amendments made by paragraphs (1) and (2) shall cease to have force or effect on October 1, 2021".

(C) RESPONSIBILITY OF LABOR SECRETARY.—In the event of an injury to such an intermittent disaster-response appointee, the Secretary of Labor shall be responsible for making determinations as to whether the claimant is entitled to compensation or other benefits in accordance with chapter 81 of title 5, United States Code.

(D) COMPUTATION OF PAY.—In the event of an injury to such an intermittent disaster response appointee, the position of the employee shall be deemed to be "one which would have afforded employment for substantially a whole year", for purposes of section 8114(d)(2) of such title.

(E) CONTINUATION OF PAY.—The weekly pay of such an employee shall be deemed to be the hourly pay in effect on the date of the injury multiplied by 40, for purposes of computing benefits under section 8118 of such title.

(3) EMPLOYMENT AND REEMPLOYMENT RIGHTS.—

(A) IN GENERAL.—Service as an intermittent disaster-response appointee when the Secretary activates the National Disaster Medical System or when the individual participates in a training program authorized by the Assistant Secretary for Preparedness and Response or a comparable official of any Federal agency specified in subsection (a)(2)(B) shall be deemed "service in the uniformed services" for purposes of chapter 43 of title 38, United States Code, pertaining to employment and reemployment rights of individuals who have performed service in the uniformed services (regardless of whether the individual receives compensation for such participation). All rights and obligations of such persons and procedures for assistance, enforcement, and investigation shall be as provided for in chapter 43 of title 38, United States Code.

(B) NOTICE OF ABSENCE FROM POSITION OF EMPLOYMENT.—Preclusion of giving notice of service by necessity of Service as an intermittent disaster-response appointee when the Secretary activates the National Disaster Medical System shall be deemed preclusion by "military necessity" for purposes of section 4312(b) of title 38, United States Code, pertaining to giving notice of absence from a position of employment. A determination of such necessity shall be made by the Secretary, in consultation with the Secretary of Defense, and shall not be subject to judicial review.

(4) LIMITATION.—An intermittent disaster-response appointee shall not be deemed an employee of the Department of Health and Human Services for purposes other than those specifically set forth in this section.

(e) RULE OF CONSTRUCTION REGARDING USE OF COMMISSIONED CORPS.—If the Secretary assigns commissioned officers of the Regular or Reserve Corps to serve with the National Disaster Medical System, such assignments do not affect the terms and conditions of their appointments as commissioned officers of the Regular or Reserve Corps, respectively (including with respect to pay and allowances, retirement, benefits, rights, privileges, and immunities).

(f) DEFINITION.—For purposes of this section, the term "auxiliary services" includes mortuary services, veterinary services, and other services that are determined by the Secretary to be appropriate with respect to the needs referred to in subsection (a)(3)(A).

(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of providing for the Assistant Secretary for Preparedness and Response and the operations of the National Disaster Medical System, other than purposes for which amounts in the Public Health Emergency Fund under section 319 are available, there are authorized to be appropriated $57,400,000 for each of fiscal years 2019 through 2023.

SEC. 2813. [42 U.S.C. 300hh–15] VOLUNTEER MEDICAL RESERVE CORPS.

(a) IN GENERAL.—Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary, in collaboration with State, local, and tribal officials, shall build on State, local, and tribal programs in existence on the date of enactment of such Act to establish and maintain a Medical Reserve Corps (referred to in this section as the "Corps") to provide for an adequate supply of volunteers in the case of a Federal, State, local, or tribal public health emergency. The Secretary may appoint a Director to head the Corps and oversee the activities of the Corps chapters that exist at the State, local, Tribal, and territorial levels.

(b) STATE, LOCAL, AND TRIBAL COORDINATION.—The Corps shall be established using existing State, local, and tribal teams and shall not alter such teams.

(c) COMPOSITION.—The Corps shall be composed of individuals who—

(1)(A) are health professionals who have appropriate professional training and expertise as determined appropriate by the Director of the Corps; or

(B) are non-health professionals who have an interest in serving in an auxiliary or support capacity to facilitate access to health care services in a public health emergency;

(2) are certified in accordance with the certification program developed under subsection (d);

(3) are geographically diverse in residence;

(4) have registered and carry out training exercises with a local chapter of the Medical Reserve Corps; and

(5) indicate whether they are willing to be deployed outside the area in which they reside in the event of a public health emergency.

(d) CERTIFICATION; DRILLS.—

(1) CERTIFICATION.—The Director, in collaboration with State, local, and tribal officials, shall establish a process for the periodic certification of individuals who volunteer for the Corps, as determined by the Secretary, which shall include the completion by each individual of the core training programs developed under section 319F, as required by the Director. Such certification shall not supercede State licensing or credentialing requirements.

(2) DRILLS.—In conjunction with the core training programs referred to in paragraph (1), and in order to facilitate the integration of trained volunteers into the health care sys-

tem at the local level, Corps members shall engage in periodic training exercises to be carried out at the local level. Such training exercises shall, as appropriate and applicable, incorporate the needs of at-risk individuals in the event of a public health emergency.

(e) DEPLOYMENT.—During a public health emergency, the Secretary shall have the authority to activate and deploy willing members of the Corps to areas of need, taking into consideration the public health and medical expertise required, with the concurrence of the State, local, or tribal officials from the area where the members reside.

(f) EXPENSES AND TRANSPORTATION.—While engaged in performing duties as a member of the Corps pursuant to an assignment by the Secretary (including periods of travel to facilitate such assignment), members of the Corps who are not otherwise employed by the Federal Government shall be allowed travel or transportation expenses, including per diem in lieu of subsistence.

(g) IDENTIFICATION.—The Secretary, in cooperation and consultation with the States, shall develop a Medical Reserve Corps Identification Card that describes the licensure and certification information of Corps members, as well as other identifying information determined necessary by the Secretary.

(h) INTERMITTENT DISASTER-RESPONSE PERSONNEL.—

(1) IN GENERAL.—For the purpose of assisting the Corps in carrying out duties under this section, during a public health emergency, the Secretary may appoint selected individuals to serve as intermittent personnel of such Corps in accordance with applicable civil service laws and regulations. In all other cases, members of the Corps are subject to the laws of the State in which the activities of the Corps are undertaken.

(2) APPLICABLE PROTECTIONS.—Subsections (c)(2), (d), and (e) of section 2812 shall apply to an individual appointed under paragraph (1) in the same manner as such subsections apply to an individual appointed under section 2812(c).

(3) LIMITATION.—State, local, and tribal officials shall have no authority to designate a member of the Corps as Federal intermittent disaster-response personnel, but may request the services of such members.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $11,200,000 for each of fiscal years 2019 through 2023.

SEC. 2814. [42 U.S.C. 300hh–16] AT-RISK INDIVIDUALS.

The Secretary, acting through such employee of the Department of Health and Human Services as determined by the Secretary and designated publicly (which may, at the discretion of the Secretary, involve the appointment or designation of an individual as the Director of At-Risk Individuals), shall—

(1) monitor emerging issues and concerns as they relate to medical and public health preparedness and response for at-risk individuals in the event of a public health emergency declared by the Secretary under section 319;

(2) oversee the implementation of the preparedness goals described in section 2802(b) with respect to the public health

and medical needs of at-risk individuals in the event of a public health emergency, as described in section 2802(b)(4);

(3) assist other Federal agencies responsible for planning for, responding to, and recovering from public health emergencies in addressing the needs of at-risk individuals;

(4) provide guidance to and ensure that recipients of State and local public health grants include preparedness and response strategies and capabilities that take into account the medical and public health needs of at-risk individuals in the event of a public health emergency, as described in section 319C–1(b)(2)(A)(iii);

(5) ensure that the contents of the strategic national stockpile take into account at-risk populations as described in section 2802(b)(4)(B);

(6) oversee curriculum development for the public health and medical response training program on medical management of casualties, as it concerns at-risk individuals as described in subparagraphs (A) through (C) of section 319F(a)(2);

(7) disseminate and, as appropriate, update novel and best practices of outreach to and care of at-risk individuals before, during, and following public health emergencies in as timely a manner as is practicable, including from the time a public health threat is identified;

(8) ensure that public health and medical information distributed by the Department of Health and Human Services during a public health emergency is delivered in a manner that takes into account the range of communication needs of the intended recipients, including at-risk individuals; and

(9) facilitate coordination to ensure that, in implementing the situational awareness and biosurveillance network under section 319D, the Secretary considers incorporating data and information from Federal, State, local, Tribal, and territorial public health officials and entities relevant to detecting emerging public health threats that may affect at-risk individuals, such as pregnant and postpartum women and infants, including adverse health outcomes of such populations related to such emerging public health threats.

SEC. 2815. [42 U.S.C. 300hh–17] EMERGENCY RESPONSE COORDINATION OF PRIMARY CARE PROVIDERS.

The Secretary, acting through Administrator[2] of the Health Resources and Services Administration, and in coordination with the Assistant Secretary for Preparedness and Response, shall

(1) provide guidance and technical assistance to health centers funded under section 330 and to State and local health departments and emergency managers to integrate health centers into State and local emergency response plans and to better meet the primary care needs of populations served by health centers during public health emergencies; and

(2) encourage employees at health centers funded under section 330 to participate in emergency medical response programs including the National Disaster Medical System authorized in section 2812, the Volunteer Medical Reserve Corps au-

[2] So in law. Probably should read "the Administrator".

thorized in section 2813, and the Emergency System for Advance Registration of Health Professions Volunteers authorized in section 319I.

Subtitle C—Strengthening Public Health Surveillance Systems

SEC. 2821. [42 U.S.C. 300hh–31] EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may also be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by—

(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases, including mosquito and other vector-borne diseases, and other conditions of public health importance;

(2) enhancing laboratory practice as well as systems to report test orders and results electronically;

(3) improving information systems including developing and maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

(4) developing and implementing prevention and control strategies.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $190,000,000 for each of fiscal years 2019 through 2023, of which—

(1) not less than $95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).

SEC. 2822. [42 U.S.C. 300hh-32] ENHANCED SUPPORT TO ASSIST HEALTH DEPARTMENTS IN ADDRESSING VECTOR-BORNE DISEASES.

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may enter into cooperative agreements with health departments of States, political subdivisions of States, and Indian Tribes and Tribal organizations in areas at high risk of vector-borne diseases in order to increase

capacity to identify, report, prevent, and respond to such diseases and related outbreaks.

(b) ELIGIBILITY.—To be eligible to enter into a cooperative agreement under this section, an entity described in subsection (a) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a plan that describes—

(1) how the applicant proposes to develop or expand programs to address vector-borne disease risks, including through—

(A) related training and workforce development;

(B) programmatic efforts to improve capacity to identify, report, prevent, and respond to such disease and related outbreaks; and

(C) other relevant activities identified by the Director of the Centers for Disease Control and Prevention, as appropriate;

(2) the manner in which the applicant will coordinate with other Federal, Tribal, and State agencies and programs, as applicable, related to vector-borne diseases, as well as other relevant public and private organizations or agencies; and

(3) the manner in which the applicant will evaluate the effectiveness of any program carried out under the cooperative agreement.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $20,000,000 for each of fiscal years 2021 through 2025.

SEC. 2823. [300hh–33] PUBLIC HEALTH DATA SYSTEM MODERNIZATION.

(a) EXPANDING CDC AND PUBLIC HEALTH DEPARTMENT CAPABILITIES.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

(A) conduct activities to expand, modernize, improve, and sustain applicable public health data systems used by the Centers for Disease Control and Prevention, including with respect to the interoperability and improvement of such systems (including as it relates to preparedness for, prevention and detection of, and response to public health emergencies); and

(B) award grants or cooperative agreements to State, local, Tribal, or territorial public health departments for the expansion and modernization of public health data systems, to assist public health departments and public health laboratories in—

(i) assessing current data infrastructure capabilities and gaps to—

(I) improve and increase consistency in data collection, storage, and analysis; and

(II) as appropriate, improve dissemination of public health-related information;

(ii) improving secure public health data collection, transmission, exchange, maintenance, and analysis,

including with respect to demographic data, as appropriate;

(iii) improving the secure exchange of data between the Centers for Disease Control and Prevention, State, local, Tribal, and territorial public health departments, public health laboratories, public health organizations, and health care providers, including by public health officials in multiple jurisdictions within such State, as appropriate, and by simplifying and supporting reporting by health care providers, as applicable, pursuant to State law, including through the use of health information technology;

(iv) enhancing the interoperability of public health data systems (including systems created or accessed by public health departments) with health information technology, including with health information technology certified under section 3001(c)(5);

(v) supporting and training data systems, data science, and informatics personnel;

(vi) supporting earlier disease and health condition detection, such as through near real-time data monitoring, to support rapid public health responses;

(vii) supporting activities within the applicable jurisdiction related to the expansion and modernization of electronic case reporting; and

(viii) developing and disseminating information related to the use and importance of public health data.

(2) DATA STANDARDS.—In carrying out paragraph (1), the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, as appropriate and in consultation with the Office of the National Coordinator for Health Information Technology, designate data and technology standards (including standards for interoperability) for public health data systems, with deference given to standards published by consensus-based standards development organizations with public input and voluntary consensus-based standards bodies.

(3) PUBLIC-PRIVATE PARTNERSHIPS.—The Secretary may develop and utilize public-private partnerships for technical assistance, training, and related implementation support for State, local, Tribal, and territorial public health departments, and the Centers for Disease Control and Prevention, on the expansion and modernization of electronic case reporting and public health data systems, as applicable.

(b) REQUIREMENTS.—

(1) HEALTH INFORMATION TECHNOLOGY STANDARDS.—The Secretary may not award a grant or cooperative agreement under subsection (a)(1)(B) unless the applicant uses or agrees to use standards endorsed by the National Coordinator for Health Information Technology pursuant to section 3001(c)(1) or adopted by the Secretary under section 3004.

(2) WAIVER.—The Secretary may waive the requirement under paragraph (1) with respect to an applicant if the Secretary determines that the activities under subsection (a)(1)(B)

cannot otherwise be carried out within the applicable jurisdiction.

(3) APPLICATION.—A State, local, Tribal, or territorial health department applying for a grant or cooperative agreement under this section shall submit an application to the Secretary at such time and in such manner as the Secretary may require. Such application shall include information describing—

(A) the activities that will be supported by the grant or cooperative agreement; and

(B) how the modernization of the public health data systems involved will support or impact the public health infrastructure of the health department, including a description of remaining gaps, if any, and the actions needed to address such gaps.

(c) STRATEGY AND IMPLEMENTATION PLAN.—Not later than 180 days after the date of enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a coordinated strategy and an accompanying implementation plan that identifies and demonstrates the measures the Secretary will utilize to—

(1) update and improve applicable public health data systems used by the Centers for Disease Control and Prevention; and

(2) carry out the activities described in this section to support the improvement of State, local, Tribal, and territorial public health data systems.

(d) CONSULTATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall consult with State, local, Tribal, and territorial health departments, professional medical and public health associations, associations representing hospitals or other health care entities, health information technology experts, and other appropriate public or private entities regarding the plan and grant program to modernize public health data systems pursuant to this section. Activities under this subsection may include the provision of technical assistance and training related to the exchange of information by such public health data systems used by relevant health care and public health entities at the local, State, Federal, Tribal, and territorial levels, and the development and utilization of public-private partnerships for implementation support applicable to this section.

(e) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this section, the Secretary shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

(1) a description of any barriers to—

(A) public health authorities implementing interoperable public health data systems and electronic case reporting;

(B) the exchange of information pursuant to electronic case reporting;

(C) reporting by health care providers using such public health data systems, as appropriate, and pursuant to State law; or

(D) improving demographic data collection or analysis;

(2) an assessment of the potential public health impact of implementing electronic case reporting and interoperable public health data systems; and

(3) a description of the activities carried out pursuant to this section.

(f) ELECTRONIC CASE REPORTING.—In this section, the term "electronic case reporting" means the automated identification, generation, and bilateral exchange of reports of health events among electronic health record or health information technology systems and public health authorities.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $100,000,000 for each of fiscal years 2021 through 2025.